Trauma Care Facility
Self-Assessment Categorization Application

Hospital/Emergency Care Facility Information

Name of Hospital/Emergency Care Facility:

Hospital/Emergency Care Facility Address:

City:

State:

ZIP:

Trauma Care Facility ID Number:

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Trauma Care Facility Verification / Re-verification

I. Verification / Re-verification Self Assessment Categorization Application

A. A self assessment categorization application for verification / re-verification may be obtained from the Iowa Department of Public Health, Bureau of EMS, 321 E. 12th Street, Des Moines, Iowa, 50319-0075. The EMS office phone number is 1-800-SAVE-EMS, (1-800-728-3367). Or access the application at www.idph.state.ia.us/EMS, the department's EMS web site.

B. Certification of a hospital or emergency care facility will be awarded by the department to the official name and address of the requesting facility. If a facility has more than one campus it is the responsibility of the facility to educate the public about the location of the trauma care facility. This will be confirmed during the verification / re-verification process.

C. As part of the verification / re-verification application, involve members from the administrative staff, medical staff, nursing staff, and other health care providers participating in trauma care delivery at the certified trauma care facility. This should include the trauma committee or standing committee that deals with trauma issues.

D. Hospitals currently verified by the American College of Surgeons (ACS) will be accepted as having the equivalent of verification / re-verification and certification as a trauma care facility in Iowa -- provided that all policy, reporting, and administrative rules have been met.

E. Carefully and completely answer all questions appropriate for the level of categorization and verification / re-verification.

The information provided in the verification / re-verification application will be used by the department in determining hospital or emergency care facility categorization and verification as a resource (level I), regional (level II), area (level III), or community (level IV) trauma care facility. The department and verification survey team will use this information prior to, during, and after the facility's certification.

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F. Submit the verification / re-verification self-assessment categorization application electronically to:

Michelle.fischer@idph.iowa.gov

G. The department will review the verification / re-verification self assessment categorization application. If the applicant facility appears to be in compliance with the categorization criteria, administrative rules, and Code of Iowa Chapter 147A, the department will arrange for a verification survey. If the applicant facility is found to NOT be in compliance, the department will contact the facility for a consultation visit. The consultation visit may be by phone or personal visit. An onsite verification survey must be conducted for resource, regional, and area trauma care facilities. An application review by a verification team member will be completed for community trauma care facilities.

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II. WITHDRAWAL OF RE-VERIFICATION APPLICATION

A. A facility that has submitted a re-verification self assessment categorization application may withdraw the application if that facility has a need to change the level of categorization and verification requested. The facility must submit a written justification to the Iowa Department of Public Health, Bureau of EMS, 321 E. 12th Street, Des Moines, Iowa, 50319-0075. A new re-verification application will be submitted by the facility to the department within thirty (30) days of receipt of the withdrawal letter by the department.

III. LEVELS OF CATEGORIZATION AND VERIFICATION

A. Categorization of hospitals and emergency care facilities provides the foundation for identification of facility, equipment and personnel resources for trauma care across the state. Categorization includes four (4) levels:

Resource (**Level I)**
Regional (Level II)
Area (Level III)
Community (Level IV)

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IV. TIME TABLE

A. The department will send a re-verification self assessment categorization application to the hospital or emergency care facility approximately **six** (**6) months** prior to its certification expiration date. The application will be sent to the Trauma Nurse Coordinator and/or administrator of the facility listed in the most current Iowa Hospital Association Membership Directory. A tentative date for an onsite verification visit will be scheduled.

B. Hospitals and emergency care facilities **must** submit the re-verification self-assessment categorization application to the department **four (4) months** prior to the trauma care facility certification expiration date.

C. A hospital or emergency care facility may apply to the department at any time for a change in level of categorization and verification through submission of a re-verification self-assessment categorization application.

V. FEES FOR THE VERIFICATION / RE-VERIFICATION SELF-ASSESSMENT CATEGORIZATION APPLICATION

A. There are no fees for the re-verification self assessment categorization application.

B. The applicant facility is responsible for any associated cost for completing and submitting the verification / re-verification self assessment categorization application.

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VI. ASSISTANCE WITH COMPLETING THE VERIFICATION / RE-VERIFICATION APPLICATION

Contact the State Trauma System Manager at the Iowa Department of Public Health, Bureau of EMS, at 1-800-SAVE-EMS or (515) 281-0443 or by email Janet.Houtz@idph.iowa.gov with any questions or for any assistance in completing the verification / re-verification self assessment categorization application.

VII. AMERICAN COLLEGE OF SURGEONS (ACS) VERIFIED HOSPITALS

Any requests for consultation or verification by the American College of Surgeons (ACS) by a hospital or emergency care facility should be submitted in writing to the department. All subsequent documentation of the consultation visit and or verification visit must be submitted to the department as outlined below.

The following documentation must be provided to the department for current ACS-verified hospitals,

1. Letter of request**.**
2. Current copy of the facility's ACS verification certificate**.**
3. Current copy of the facility's ACS verification application**.**
5. Current copy of the facility's ACS verification report**.**
6. Narrative describing how the recommendations in the ACS verification report have been handled by the facility**.**
7. Copy of the following trauma registry reports: 1) all transfers out of the facility (last year), 2) admissions with diagnosis and admitting physician (last year), 3) trauma service summary report (last year), 4) death summary (last year)**.**
8. Narrative describing how consultation (prior to transfer) and follow-up (following transfer) is provided to the trauma care facility attending physician and/or trauma service transferring trauma patients to your facility**).**
9. Describe specifically what outreach trauma education is provided by the facility. Include title of education, instructor name and credentials, frequency of offering, location, and attendance**.**
10. Describe what prevention activities are provided by your trauma service. Include type, frequency of offering and locations**.**

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I. Purpose of Review (all levels)

A. Type of Review requested:

☐ Verification (New Facility or New Level)

☐ Re-verification (Same Level)

Level of trauma care facility categorization requested:

☐ Resource (Level I)

☐ Regional (Level II)

☐ Area (Level III)

☐ Community (Level IV)

B. How many prior reviews has the Iowa Department of Public Health conducted for this hospital/emergency care facility? ☐ None (If None, skip to Section II)

C. Date of most recent verification or re-verification review:

If verified, date of verification:

1. Type of most recent review:

☐ Verification

☐ Re-verification

☐ Consultation

2. Level of trauma care facility categorization for most recent review:

☐ Resource (Level I)

☐ Regional (Level II)

☐ Area (Level III)

☐ Community (Level IV)

3. Number of deficiencies found with last review.

List any deficiencies:

4. Describe how the deficiencies were corrected since the last review.

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II. Hospital/Emergency Care Facility Information

A. Are all of the trauma facilities on one campus?

☐ Yes ☐ No

If 'No' describe:

B. Hospital Beds.

Hospital Beds	Adult	Pediatric	Total
Licensed			
Staffed			

C. Hospital/Emergency Care Facility Commitment

1. Is there written documentation within the past 12 months supporting the trauma program signed by the hospital/emergency care facility's board or governing body, administration, medical staff and nursing staff? ☐ Yes ☐ No

   Attach the resolution to this application as **Attachment #1**.

   The original document should also be made available at an onsite visit.

2. Describe the hospital/administrative commitment to trauma.

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III. TRAUMA SERVICE

A. Trauma Medical Director

1. Please complete **Attachment #2**

2. Provide the job description for the trauma service medical director as **Attachment #3**.

3. Name:

4. Date of appointment to this position

5. Peer Review Meeting Attendance %

B. Trauma/General Surgery ☐ Not Applicable

1. List all surgeons currently taking trauma call. (**Attachment #4**.)

2. Does the trauma/general surgeon on call provide care for non-trauma emergencies?

   ☐ Yes ☐ No

3. Do trauma/general surgeons take in-house call? ☐ Yes ☐ No

4. Is there a published backup call schedule for the trauma surgeons?
   ☐ Yes ☐ No
   The most recent six (6) months schedule should be available at an onsite visit.

5. Number of trauma/general surgeons with added certifications in critical care:

6. Number of trauma fellowship-trained surgeons on call panel:

7. Is the trauma/general surgeon dedicated to one hospital/emergency care facility while on call?
   ☐ Yes ☐ No

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C. Trauma Program Manager(TPM) or Trauma Nurse Coordinator (TNC) or Trauma Coordinator (TC)

1. Name:

   Education:

EMT - Basic:	☐ Yes	☐ No	Year:
EMT - Intermediate:	☐ Yes	☐ No	Year:
EMT - Paramedic:	☐ Yes	☐ No	Year:
Paramedic Specialist:	☐ Yes	☐ No	Year:
Associate Nursing Degree:	☐ Yes	☐ No	Year:
Bachelor Nursing Degree:	☐ Yes	☐ No	Year:
Masters Nursing Degree:	☐ Yes	☐ No	Year:
Other:	☐ Yes	☐ No	Year:

2. Is the TPM/TNC/TC a full-time position? ☐Yes ☐ No

   If 'No', please give a detailed explanation

3. TPM/TNC/TC Reporting Status:

   Check all that apply.

   ☐ Trauma Service Medical Director
   ☐ Nursing Administration
   ☐ ED Director
   ☐ Other:

4. Date of appointment to this position

5. TPM/TNC/TC job description provided as **Attachment #5**.

6. List ancillary support personnel (names, titles, and FTEs):

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D. Trauma Service

1. Is there a formalized trauma service at the facility? ☐ Yes ☐ No

2. Describe, in detail, the trauma service, including how the trauma medical director oversees all aspects of the multi-disciplinary care, from the time of injury through discharge.

3. Does the trauma director have the authority to affect all aspects of trauma care including the recommendation to remove members from and/or appoint members to the trauma panel?
   ☐ Yes ☐ No
   If No, please provide an explanation as to why not.

4. Define the additional credentialing criteria/qualifications as described in the facility's credentialing policy for serving on the trauma panel in addition to hospital credentials.

E. Trauma Team Activation

1. Describe in detail the trauma team activation response.

2. How many levels of trauma team activation are there at this facility, and list the criteria for each level of response:

3. Who has the authority to activate the trauma team?
   ☐ EMS
   ☐ Hospital Communications
   ☐ ED Nurse
   ☐ ED Physician
   ☐ Other
   If 'other', provide explanation:

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4. Statistics for level of response.

   ☐ Trauma Service Summary Report Provided for reporting year

   (Mandatory for all Collector users)

Trauma Team Activation	Number	Percent
Partial		
Full		
NFS		
Consult		

5. Describe in detail how a full trauma team activation is instituted.

6. What percent of time is the trauma/general surgeon or emergency physician present in the ED on patient arrival for the highest level of activation? %

7. What percent of time is the trauma/general surgeon or emergency physician present in the ED within 30 minutes for the highest level of activation? %

Trauma Response/Activation (continued)

Define which trauma team members would respond to each level of activation?

	Activation Level		
Responder	Partial	Full	Other

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F. Trauma/Hospital Statistical Data

1. Total number of emergency department (ED) visits for reporting year:
   (Include patients who expired in ED, exclude those who were Dead On Arrival).
   From Month/Year To Month/Year

2. Total number of Farm and Agricultural related ED visits for same reporting year:

3. Total number of trauma-related ED visits for same reporting year, with ICD-9 code between 800.00 and 959.9 (Include Pediatric admissions in 3 through 6).

4. Total number of Trauma Admissions beyond the emergency department
   (Include Pediatric admissions in 3 through 6).

Admitting Service	Number of Admissions
Trauma Service	
Orthopedic Service	
Neurosurgery Service	
Other Surgical Service	
Non-Surgical Service	
Total Trauma Admissions	

a. Penetrating trauma percentage:
   Blunt trauma percentage
   Thermal Percentage

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5. Disposition from ED for trauma patient admitted beyond the ED.
   (Include Pediatric admissions in 3 through 6)

Disposition	Total Number	Number Admitted to Trauma Service
ED to OR		
ED to ICU		
ED to Floor		
Total		

6. Injury Severity and Mortality. (Include Pediatric admissions in 3 through 6).

ISS	Number	Deaths	% Mortality
0 – 9			
10 – 15			
16 – 24			
≥ 25			
Total			

   a. Explain any inconsistency between total admissions, total disposition from ED and total ISS numbers

7. Number of trauma related transfers:

TRANSFERS	AIR	GROUND	TOTAL
Trauma Transfers In			
Trauma Transfers Out			

G. Trauma Bypass

1. Does the facility have a bypass protocol? ☐ Yes ☐ No

2. Has the facility gone on trauma bypass during the previous year?
   ☐ Yes ☐ No
   If 'Yes', complete **Attachment #6**

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H. Neurosurgery (Skip to I if Community TCF)

1. Neurosurgeon liaison to the trauma program. **Attachment #7**.
   List all neurosurgeons taking trauma call. **Attachment #8**.

2. Are any of the neurosurgeons taking simultaneous trauma call at more than one hospital?
   ☐ Yes ☐ No
   If 'Yes', please describe

3. Number of emergency neurosurgical operative procedures (excluding ICP monitor placement), done within 24 hours of admission during the reporting period.

4. Is there a published backup call schedule for the neurosurgeons?
   ☐ Yes ☐ No

I. Orthopedic Surgery

1. Orthopedic liaison to the trauma program. **Attachment #9**.
   List all orthopedic surgeons taking trauma call. **Attachment #10**.

2. Are any of the orthopedic surgeons taking simultaneous trauma call at more than one hospital?
   ☐ Yes ☐ No

3. Is there a published backup call schedule for the orthopedic surgeons?
   ☐ Yes ☐ No

4. Number of operative procedures performed within 24 hours of admission:

5. Number of trauma fellowship-trained orthopedic surgeons on the trauma call panel:

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J. On-call and promptly available 24 hours/day at this facility:

a.	Cardiac Surgery	☐ Yes ☐ No
b.	Hand Surgery	☐ Yes ☐ No
c.	Microvascular/Replant Surgery	☐ Yes ☐ No
d.	Obstetrics/gynecological Surgery	☐ Yes ☐ No
e.	Ophthalmic Surgery	☐ Yes ☐ No
f.	Oral/maxillofacial	☐ Yes ☐ No
g.	Plastic Surgery	☐ Yes ☐ No
h.	Critical care Medicine	☐ Yes ☐ No
i.	Radiology	☐ Yes ☐ No
j.	Thoracic Surgery	☐ Yes ☐ No

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IV. Hospital/Emergency Care Facilities

A. Emergency Department

1. Emergency Medical Liaison to trauma program. **Attachment #11**
   (In the community level trauma care facility this may be the same as the TSMD)

2. List **all** emergency department physicians and mid-level practitioners who treat trauma patients. **Attachment #12**

3. Does the emergency department physician have responsibilities outside of the Emergency Department while on call? ☐ Yes ☐ No

   If 'Yes', does the PI program monitor/address outcomes? ☐ Yes ☐ No

4. Describe in detail the trauma-related continuing education provided for Nurses and/or EMS Providers working in the ED:

   a. Extra certifications for ED nursing staff:

      TNCC or ATCN%

      PALS%

      ACLS%

      Audit ATLS%

      CEN%

      Other (Enter Description(s) and Percentage(s))

   b. Extra certifications for EMS staff:

      PHTLS%

      PALS%

      ACLS%

      Audit ATLS%

      Other (Enter Description(s) and Percentage(s))

6. Does the hospital have a separate area or separate equipment in the ED for pediatric resuscitation? ☐ Yes ☐ No

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7. Equipment located in the Emergency Department for patients of all ages:

a.	Airway control & ventilation	☐ Yes ☐ No
b.	Pulse oximetry	☐ Yes ☐ No
c.	Suction devices	☐ Yes ☐ No
d.	Electrocardiograph/oscilloscope-defibrillator	☐ Yes ☐ No
e.	Internal paddles	☐ Yes ☐ No
f.	CVP monitoring equipment	☐ Yes ☐ No
g.	Standard IV fluids & administration sets	☐ Yes ☐ No
h.	Large-bore intravenous catheters	☐ Yes ☐ No
i.	Sterile surgical sets for:	
	i. Cricothyrotomy	☐ Yes ☐ No
	ii. Thoracostomy	☐ Yes ☐ No
j.	Venous cut down	☐ Yes ☐ No
k.	Central line insertion	☐ Yes ☐ No
l.	Thoracotomy	☐ Yes ☐ No
m.	Peritoneal lavage	☐ Yes ☐ No
n.	Arterial catheters	☐ Yes ☐ No
o.	Drugs for emergency care	☐ Yes ☐ No
p.	X-ray availability 24 hours/day	☐ Yes ☐ No
q.	Spinal immobilization devices	☐ Yes ☐ No
r.	Cervical traction devices	☐ Yes ☐ No
s.	Pediatric resuscitation tape	☐ Yes ☐ No
t.	Thermal control equipment	
	i. for patient	☐ Yes ☐ No
	ii. for blood and fluids	☐ Yes ☐ No
u.	Rapid infuser system	☐ Yes ☐ No
v.	Qualitative end-tidal CO_2 determination	☐ Yes ☐ No
w.	Communication with EMS vehicles	☐ Yes ☐ No
x.	Availability of ultrasound	☐ Yes ☐ No

B. Radiology

1. Is there adult and pediatric resuscitation and monitoring equipment available in the radiology suite? ☐ Yes ☐ No

2. Is there a CT technician available in hospital 24/7?

   ☐ Yes ☐ No

   If 'No', is there a Performance Improvement Program, which reviews timeliness of CT response?

   ☐ Yes ☐ No

3. Are radiologists in-house 24/7? ☐ Yes ☐ No

   If 'No', who reads x-rays after hours?

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4. What is the misread rate on preliminary radiologist interpretations of radiographic studies?

5. If an error is identified, what is the policy for notifying the physician?

C. Operating Room

1. Number of operating rooms:

   Describe in detail, the location of the operating suite in comparison to the location of the emergency department.

2. Do you have operating room personnel in-house 24/7 to start an operation? ☐ Yes ☐ No
   If 'No', number of teams on call and expected response time.

   Number of teams on backup call:

3. Describe the mechanism for opening the OR if the team is not in-house 24/7.

4. Anesthesia liaison to the trauma program as **Attachment #13**.

5. Does the facility have anesthesia available in the hospital 24/7?
   ☐ Yes ☐ No
   If 'No', is there a performance improvement program monitoring anesthesia response?
   ☐ Yes ☐ No

6. Number of anesthesiologists on staff:

7. How many anesthesiologists are on backup call during off-hours?

8. Does the hospital use certified registered nurse anesthetics (CRNA)?
   ☐ Yes ☐ No
   If 'Yes', are they involved in the care of the trauma patient?
   ☐ Yes ☐ No

D. PACU (Post-Anesthesia Care Unit)

1. Number of Beds.

2. Extra certifications for PACU staff.

   TNCC %

   ACLS %

   PALS %

   Audit ATLS %

   CCRN %

E. Intensive Care Unit (ICU)

If your facility has no ICU, enter 0 in total ICU beds and skip to F

1. ICU Beds.

   Total ICU beds:*

   Total Pediatric:

   Total Surgical:

   Total Step-down:

   *(Includes medical, coronary, surgical, pediatric, etc)

2. Who is the surgical director of the ICU?

   Name:

3. Does the surgical director of the ICU have added certification in surgical critical care?

   ☐ Yes ☐ No

4. Who is responsible for care of the trauma patient in the ICU?

   ☐ Surgeon

   ☐ ICU Intensivist

   ☐ Other

   If 'other', please explain.

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5. Who provides immediate response for life-threatening emergencies in the ICU after hours?

6. Describe how quality of care issues are resolved in the ICU:

7. What are the requirements for nurses working in the ICU?

8. Nursing staff demographics:

   Extra certifications for ICU Nursing Staff:

   CCRN %

   ACLS %

   PALS %

   TNCC %

   Audit ATLS%

   Other % (Enter category and percent)

10. Describe in detail the trauma-related continuing education provided for nurses working in ICU:

F. Blood Bank

1. Source of blood products is

   ☐ Hospital processed

   ☐ Regional Blood Bank

   Regional blood bank name and location:

2. Does the facility have a massive transfusion protocol? ☐ Yes ☐ No

   If 'Yes', describe the process in which the protocol is implemented:

3. Does the facility have uncross-matched blood immediately available?

   ☐ Yes ☐ No

   If 'Yes', define how many units are available and the mechanism on how to obtain:

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4. What is the average turnaround time for:

   Type specific blood (minutes):

   Full cross-match (minutes):

5. Is there immediate access to the following:

   ☐ Cryoprecipitate

   ☐ Fresh Frozen Plasma

   ☐ Platelets

   ☐ Factor VIII

   ☐ Factor IX

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V. Pediatric Trauma Program

A. Pediatric Trauma

Define the age of pediatric patient.

1. Pediatric Trauma Admissions

Service	Number of Admissions
Trauma	
Orthopedic	
Neurosurgical	
Other Surgical	
Non-Surgical	
Total Trauma Admissions	

a. Injury Severity and Mortality:

ISS Category	Number	Deaths	% Mortality
0 – 9			
10 – 15			
16 – 24			
≥ 25			
Total			

2. Is there a separate pediatric trauma team? ☐ Yes ☐ No
   If 'Yes', describe how this differs from the adult team.

3. Is there a separate pediatric ICU? ☐ Yes ☐ No
   If 'Yes', describe in detail.
   If 'No' skip to 8

4. Who is the Medical Director of the Pediatric ICU?

5. Who is the Surgical Director of the Pediatric ICU?

6. Does the Pediatric Surgical Director have additional certifications in Surgical Critical Care?
   ☐ Yes ☐ No

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7. Which physician maintains primary responsibility for the care of the patient in the PICU?
   - ☐ Surgeon
   - ☐ Pediatric ICU Intensivist
   - ☐ If 'Other', please explain.

8. Number of physicians with additional pediatric training:
   a. General Surgery:
   b. Neurosurgery:
   c. Orthopedic Surgery:
   d. Emergency Medicine:

9. Is there pediatric resuscitation equipment in <u>all</u> patient care areas?
   ☐ Yes ☐ No

10. Nursing staff demographics:
    Extra certifications for PICU nursing staff:

    CCRN: %

    ACLS: %

    PALS: %

    APLS: %

    TNCC: %

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VI. Specialty Services

A. Rehabilitative Services (If Community level TCF, skip to C)

1. Who is the director of the rehabilitation program?
   Name:

2. Is this physician board certified? ☐ Yes ☐ No
   If 'Yes', what specialty?

3. Describe the role and relationship of the rehabilitation services to the trauma service.
   (Include where and when rehabilitation begins.)

4. What services are provided in the ICU?
   ☐ Physical therapy
   ☐ Occupational Therapy
   ☐ Speech Therapy
   ☐ Other

5. Describe, if applicable, the pediatric rehabilitation service

6. Does the facility have an in-patient rehabilitation unit? ☐ Yes ☐ No

7. What system is used to measure rehabilitation patient outcome?

B. Burn Patients

1. Number of burn patients admitted beyond the ED during the reporting year.

2. Is there a separate burn team? ☐ Yes ☐ No

3. Is the institution a verified burn center? ☐ Yes ☐ No

4. Number of burn patients transferred for acute care during reporting year.

   Burn Patients Transferred In:

   Burn Patients Transferred Out:

5. Does the facility have transfer arrangements for burn patients?

   ☐ Yes ☐ No

   If yes, list those facilities in which the burn transfer agreements are with.

C. Spinal Column Injuries

1. Number of spinal column injuries treated during the reporting year:

   How many of these patients had neurological deficits?

2. Number of patients with acute spinal column injury transferred during the reporting year?

   Transferred In:

   Transferred Out:

3. Are there any transfer arrangements for acute spinal column injury patients?

   ☐ Yes ☐ No

   If 'Yes', list those facilities in which the acute spinal column injury transfer agreements are with.

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D. Organ Procurement

1. Does the facility have an organ procurement program? ☐ Yes ☐ No
   a. If 'Yes', how many trauma referrals were made to the regional organ procurement organization the reporting year?
   b. How many trauma patient donors in the reporting year?

E. Social Services

1. Is there a dedicated social worker for trauma service? ☐ Yes ☐ No
   If 'No', what is the commitment from Social Services to the trauma patient?

2. Describe the support services available for crisis intervention and individual/family counseling.

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VII. PRE-HOSPITAL SYSTEM

A. Pre-hospital system description.

1. List the name(s) and identify trauma care facility categorization level of other trauma care facilities within a 50 mile radius of the hospital/emergency care center.

B. EMS

1. Describe in detail the physician leadership of the local EMS System.

2. Define the 'Air Medical' support services available in the area, and the type: fixed and/or rotor.

3. Does the hospital/emergency care facility serve as a base station for EMS operations?
   ☐ Yes ☐ No

4. Does the hospital/emergency care facility provide medical control?
   ☐ Yes ☐ No
   If 'No', proceed to #5
   If 'Yes', does it provide:
   Type of ground medical control for EMS:
   - ☐ Offline medical control for ground EMS
   - ☐ Online medical control for ground EMS

   Type of medical control for air EMS:
   - ☐ Offline medical control for air EMS
   - ☐ Online medical control for air EMS
   - ☐ Not Applicable

5. Describe in detail how the hospital/emergency care facility communicates with EMS for the relay of pre-hospital trauma patient information?

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6. Is the trauma service / trauma care team involved in EMS training?

   ☐ Yes ☐ No

   If 'Yes', describe in detail the involvement.

   If 'No', describe in detail why not.

7. Describe in detail how the hospital/emergency care facility is involved EMS Performance Improvement& Patient Safety (PIPS)?

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VIII. Performance Improvement & Patient Safety (PIPS)

A. Performance Improvement/Patient Safety (PIPS) program.

1. Describe the PIPS program including how issues are identified and tracked.

2. Who is responsible for loop closure of both system and peer review issues?

3. List the 10 most recently used PIPS filters, plus pediatric and hospital specific:

4. Are nursing issues reviewed in the trauma PIPS Process? ☐ Yes ☐ No
   If 'No', please describe how nursing units ensure standards and protocols are followed:

5. Are EMS issues reviewed in the trauma PIPS Process? ☐ Yes ☐ No
   If 'No', please describe how EMS agencies ensure standards and protocols are followed

B. Trauma Registry

1. Does the trauma care facility report data to the Iowa Department of Public Health in accordance with 641 – 136 (147A) ☐ Yes ☐ No
2. Please describe the process in which this is done:

3. Date of most recent data submission to the department:

4. Does the trauma care facility report Farm and Agricultural data to the Iowa Department of Public Health in accordance with 641 – 1.3 (139A) ☐ Yes ☐ No
5. Please describe the process in which this is done:

6. Date of most recent data submission to the department:

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7. Does the trauma care facility utilize the state provided hospital trauma registry software for trauma data collection: ☐ Yes ☐ No
   If 'no', skip to section C.

8. For what percentage of patients is the trauma registry data entry completed within 60 days of discharge?

9. For what percentage of patients is the trauma registry data entry completed within 90 days of discharge?

10. Describe how the trauma care facility works with the SEQIC in statewide PI activities:

C. Trauma Death Audits

1. How many trauma deaths were there during the reporting year? (Include ED deaths, and in-house deaths.)

   From Month/Year To Month/Year

   Deaths in ED (Include DOA):

   In-hospital (include OR):

   Total:

2. Autopsies have been performed on what percentage of the facility's trauma deaths?

   %

3. How are autopsy findings reported to the trauma program?

D. Multidisciplinary Trauma Committee(s)

1. Provide a description of any committee with trauma PIPS involvement, including system and peer review committees. **Attachment #14**

E. Does the facility have a protocol manual for trauma? ☐ Yes ☐ No
If 'Yes', have available on site.

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Self-Assessment Categorization Application

F. Has the trauma program instituted any 'evidenced-based' trauma management guidelines?

☐ Yes ☐ No

These should also be made available at an onsite visit.

If 'Yes', describe.

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IX. Educational Activities/Outreach Programs

A. Describe the trauma education program, including examples for physicians, nurses, and pre-hospital providers.

B. Does the facility provide counseling for patients with elevated blood alcohol content? ☐ Yes ☐ No
If so, does the facility provide any type of intervention? ☐ Yes ☐ No

C. Does the facility host/provide Advance Trauma Life Support courses?
☐ Yes ☐ No (if No, skip to D)

1. How many courses were provided during the reporting period?

   Number of provider courses:

   Number of instructor courses:

   Number of refresher courses:

D. Does the facility provide Rural Trauma Team Development courses? (If No, skip to E)
☐ Yes ☐ No

1. How many courses were provided during the reporting period?

E. Is there any hospital funding for physician, nursing or EMS trauma education? ☐ Yes ☐ No
If 'Yes', describe:

F. Describe the hospital's outreach programs for trauma such as 1-800 referral line, follow-up letters, and community hospital trauma education.

G. Does the facility have any injury prevention/public trauma education programs?
☐ Yes ☐ No

1. Who is the designated injury prevention coordinator?

2. List and briefly describe all injury prevention programs. Include any state, regional, or national affiliations for the injury prevention programs.

3. Describe how the facility calculates the effectiveness of the injury prevention programs.

Trauma Care Facility
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H. List, if possible, a minimum of 12 trauma-related presentations given outside the hospital in the last three years.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

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X. RESEARCH

A. Does this hospital have a trauma research program? ☐ Yes ☐ No
If 'No', skip this section.

B. Define the hospital's research activities.

1. Describe the hospital's organizational structure.

2. List ongoing projects...

With IRB Approval

Without IRB Approval

C. Does the hospital have any trauma-related grants? ☐ Yes ☐ No
If 'Yes', briefly describe.

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Self-Assessment Categorization Application

Name and Title of person responsible for completion of the Self Assessment Categorization Application:

Name:

Title:

Phone number:

E-mail:

Date submitted to Iowa Department of Public Health:

NOTE: A hospital or emergency care facility that imparts or conveys, or causes to be imparted or conveyed, that it is a trauma care facility, or that uses any other term to indicate or imply that the hospital or emergency care facility is a trauma care facility without having obtained a certificate of verification by the department is subject to civil penalty not to exceed $100 per day for each offense. The director may apply to the district court for a writ of injunction to restrain the use of the term "trauma care facility."

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Trauma Care Facility
Self-Assessment Categorization Application

Attachment #1

TRAUMA CARE FACILITY - Resolution

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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #2
TRAUMA MEDICAL DIRECTOR

Name:

Medical School:

Year Graduated:

Post Graduate Training (Residency):

Year Completed:

Fellowships:

Trauma	Where Completed Year Completed
Surgical Critical Care	Where Completed Year Completed
Pediatric surgery	Where Completed Year Completed
Other	Where Completed Year Completed

Board Certification: ☐ Yes ☐ No Date:

Specialty:

Specialty	Date

Added Qualifications/
Certifications:

FACS ☐ Yes ☐ No

ACEP ☐ Yes ☐ No

ATLS verified ☐ Yes ☐ No

☐ Instructor ☐ Provider Expiration Date

Trauma CME (Within the last four years)
Formal
Informal
Total

Trauma-related Societal Memberships
- ☐ AAST
- ☐ EAST
- ☐ WEST
- ☐ State of Iowa COT
- ☐ Other

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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #3
TRAUMA MEDICAL DIRECTOR – Job Description

Trauma Care Facility
Self-Assessment Categorization Application
Attachment #4
TRAUMA SURGEONS

Please list all surgeons **currently** taking trauma call

Name	Board Certification (type and year) S = American Board of Surgery CC = Critical Care	ATLS: Instructor/ Provider Status & Date of Expiration P= Provider I= Instructor	Number of Trauma CME hours in last 4 years		Frequency of trauma calls per month (Days)	Number of trauma patients admitted per year	% Attendance at PI Meeting
			Formal	Informal			

Iowa Department of Public Health

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Trauma Care Facility
Self-Assessment Categorization Application

Attachment #5

TPM/TNC/TC – Job Description

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Self-Assessment Categorization Application
Attachment #6
TRAUMA BYPASS OCCURRENCES

Please complete if you have gone on trauma bypass during the previous year

Date of Occurrence	Time of Bypass	Time Off Bypass	Reason for Bypass
Total number of occurrences of bypass during reporting period?			
Total number of hours on diversion during reporting period?			

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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #7
NEUROSURGEON LIAISON TO TRAUMA PROGRAM

Name

Medical School

Year Graduated

Post graduate training (residency)

Year completed

Fellowship

Year completed

Board certification:

Year Certified

Ever ATLS verified ☐ Yes ☐ No ☐ Instructor ☐ Provider

FACS ☐ Yes ☐ No

Societal Memberships
☐ AANS
☐ CNS
☐ Other

Trauma CME
(within the last four years)
Total
Formal
Informal

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Self-Assessment Categorization Application

Attachment #8

NEUROSURGEONS

Please list all neurosurgeons taking trauma call

Name	Board Certification (type and year)	ATLS: Instructor/ Provider Status & Date of Expiration P= Provider I= Instructor	Number of Trauma CME hours in last 4 years		Frequency of trauma calls per month (Days)	Number of trauma operations per year (non-ICP)	% Attendance at PI Meeting
			Formal	Informal			

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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #9
ORTHOPEDIC LIAISON TO TRAUMA PROGRAM

Name

Medical School

Year Graduated

Post graduate training (residency)

Year completed

Fellowship

Year completed

Board certification:

Year Certified

Ever ATLS verified ☐ Yes ☐ No ☐ Instructor ☐ Provider _____

FACS ☐ Yes ☐ No

Trauma-related Societal Memberships
☐ OTA
☐ AAOS
☐ Other

Trauma CME
(within the last three years)
Total
Formal
Informal

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Trauma Care Facility
Self-Assessment Categorization Application

Attachment #10

ORTHOPEDIC SURGEONS

Please list all orthopedic surgeons taking trauma call

Name	Board Certification (type and year)	ATLS: Instructor/ Provider Status & Date of Expiration P= Provider I= Instructor	Number of Trauma CME hours in last 4 years		Frequency of trauma calls per month (Days)	Number of trauma operations per year	% Attendance at PI Meeting
			Formal	Informal			

Iowa Department of Public Health

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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #11
EMERGENCY MEDICINE LIAISON TO TRAUMA PROGRAM

Name

Medical School

Year Graduated

Post Graduate Training (Residency):

Year Completed

Board Certification (specify Board): Year Completed

Year Completed

Year Completed

Ever ATLS verified ☐ Yes ☐ No

☐ Instructor ☐ Provider Expiration Date

RTTDC ☐ Yes ☐ No

☐ Instructor ☐ Provider Date of Course

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Trauma Care Facility
Self-Assessment Categorization Application

Attachment #12

EMERGENCY MEDICINE

Please list all emergency department physicians <u>and</u> mid-level practioners who respond to trauma team activations

Name	Board Certification (type and year)	ATLS / RTTDC: Instructor/ Provider Status & Date of Expiration P= Provider I= Instructor	Number of Trauma CME hours in last 4 years		Frequency of trauma calls per month (Days)	Number of shifts per month	% Attendance at PI Meeting
			Formal	Informal			

Iowa Department of Public Health
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Trauma Care Facility
Self-Assessment Categorization Application
Attachment #13
ANESTHESIA LIAISON TO TRAUMA PROGRAM

Name

Medical School

Year Graduated

Post graduate training (residency)

Year completed

Fellowship

Year completed

Board certification:

Year Certified

Ever ATLS verified ☐ Yes ☐ No

☐ Instructor ☐ Provider Expiration Date

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Attachment #14

PIPS COMMITTEES

Multidisciplinary Trauma Committee(s) to provide a description of any committee with trauma PI involvement, complete this table including morbidity and mortality review:

Name of Committee			
What is the purpose of the committee?			
Describe the membership using titles			
Name/Title of Chairperson			
How often does the committee meet?			
Are there attendance requirements? If yes, describe:			
Attendance of specialty panel members:	Trauma Surgeons (%) Emergency Medicine (%) Anesthesia (%) Orthopedics (%) Neurosurgery (%)	Trauma Surgeons (%) Emergency Medicine (%) Anesthesia (%) Orthopedics (%) Neurosurgery (%)	Trauma Surgeons (%) Emergency Medicine (%) Anesthesia (%) Orthopedics (%) Neurosurgery (%)
Committee reports to whom?			

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